STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. BUILDING 00 B. WING	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH WOODS VILLAGE	2233 W JEFFERSON ST KOKOMO, IN46901

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F0000	This visit was for the Recertification and State licensure survey. This visit included the investigation of complaint #IN00101011. Complaint # IN00101011: Substantiated: Federal/State deficiencies related to allegations are cited at F 241. Survey dates: December 13, 14, 15 and 16, 2011 Facility number: 000064 Provider number: 155139 AIM number: 100288770 Survey team: Tammy Alley RN TC Donna M. Smith RN Toni Maley BSW (December 13, 14, and 15, 2011) Linn Mackey RN Shelly Reed RN (December 14, 15, and 16, 2011) Census bed type: SNF: 16 SNF/NF: 144 Total: 160 Census payor type: Medicare: 42	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicaid: 88 Other: 30 Total: 160 Sample: 24 Supplemental Sample: 13 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 12/20/11 Cathy Emswiller RN			
F0241 SS=E	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on record review, observation and interview, the facility failed to ensure dignity was maintained for Residents who could not make choices when to rise in the morning by having them up before 4:30 a.m. in the morning for 10 of 10 residents observed up and dressed in a sample of 24 (Resident B, C, E, F, G, H, I, N, O, AND Q) and for 5 of 5 residents observed up and dressed in a supplemental sample of 13. Resident (D, J, K, L, and P)	F0241	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after January 11, 2012. **F241 Dignity** It is the practice of this provider to	01/11/2012

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	Findings include: 1. The record for Resident B was reviewed on 12/14/11 at 8 a.m. Current diagnoses included, but were not limited to, dementia. A 9/26/11 quarterly Minimum Data Set Assessment (MDS) indicated the resident was severely cognitively impaired and required total assistance for transfer, dressing and hygiene. On 12/13/11 at 4:30 a.m., the resident was up in his Broda chair in the second floor main dining room, fully dressed with his head down and his eyes closed. At that time during interview, CNA # 6 indicated he got the resident up around 4 a.m., he also indicated he begins getting residents up between 4 and 4:30 a.m., daily. 2. The record for Resident C was reviewed on 12/14/11 at 12:30 p.m. Current diagnoses included, but were not limited to, dementia. A 10/11/11 quarterly MDS assessment indicated the resident was cognitively impaired and required extensive assistance for transfers, dressing and hygiene.		ensure residents are provided care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Certified Nursing Assistant (C.N.A.) #3 and #6 and Licensed Practical Nurse (LPN) #2 was re-educated on appropriate times for residents to get up in the morning. · Residents B,C,D,E,F,G,H,I,J,K,L,N,O,P and Q have been asked and/or their responsible party have been asked on the residents normal time to rise in the morning. · The list for residents to get up early has been revised as to their individual preference. · Staff schedule has been revised to accommodate the appropriate get up times. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents that require staff assistance with getting up in the morning have the potential to be affected by the alleged deficient practice. · Nursing staff was re-educated on dignity and appropriate times to get residents up in the morning on 12-27-2011with post test	

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	On 12/13/11 between 4:50 and 5:05 a.m., Resident C were observed fully dressed in his chair at the dining room table with his eyes closed. This resident resided on the Alzheimer's care unit. 3. The record for Resident E was reviewed on 12/14/11 at 12:30 p.m. Current diagnoses included, but were not limited to, dementia. A 10/14/11 quarterly MDS assessment indicated the resident was cognitively impaired and required extensive assistance for transfers, dressing and hygiene. On 12/13/11 between 4:50 and 5:05 a.m., CNA #3 was observed assisting Resident #E, who was dressed, to the bathroom. At this same time during an interview, CNA #3 indicated he would start getting residents up between 4:00 a.m. to 4:30 a.m. This resident resided on the Alzheimer's care unit. 4. The record for Resident F was reviewed on 12/15/11 at 10 a.m. Current diagnoses included, but were not limited to, dementia.		administered to evaluate retention of education by the Staff Development Coordinator (SDC). · Individual preference for times to get up in the morning have been reviewed and adjusted for individual residents and care plans and C.N.A assignment sheets have been updated. · Staff schedule was revised to accommodate the appropriate get up times. · Residents have been asked and/or their responsible party have been asked on the residents normal time to rise in the morning. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Staff was re-educated on 12-27-2011, for dignity and appropriate times for residents to get up in the morning by the SDC. · Individual preferences for times to get up in the morning have been revised for individual residents · Staff schedule was revised to accommodate the appropriate get up times. · The unit managers and charge nurses will be responsible for overseeing the individual resident preference list to get up is followed daily. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The CQI tool "Dignity and Accommodation of Needs will be	

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	A 10/14/11 quarterly MDS assessment indicated the resident was cognitively impaired and required extensive assistance for dressing and hygiene. On 12/13/11 at 4:40 a.m., the resident up in his wheelchair fully dressed, sitting in the doorway of his room. 5. The record for Resident G was reviewed on 12/15/11 at 10:15 a.m. Current diagnoses included, but were not limited to, dementia. A 11/18/11 quarterly MDS assessment indicated the resident was cognitively impaired and required total assistance for transfers, dressing and hygiene. On 12/13/11 at 4:40 a.m., the resident was up in her wheelchair fully dressed in her room. 6. The record for Resident H was reviewed on 12/15/11 at 1:30 p.m. Current diagnoses included, but were not limited to, dementia. A 10/14/11 quarterly MDS assessment indicated the resident was cognitively impaired and required limited to extensive assistance for transfers, dressing		utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. · The Director of Nursing Services and /or Designee is responsible to monitor for compliance · The CQI team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance Compliance date: January 11, 2012	

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	and hygiene. On 12/13/11 between 4:50 and 5:05 a.m., Resident H was observed fully dressed in her w/c slouched down in her chair sleeping. This resident resided on the Alzheimer's care unit. 7. The record for Resident I was reviewed on 12/15/11 at 1:00 p.m. Current diagnoses included, but were not limited to, Alzheimer's Disease. A 11/18/11 annual MDS assessment indicated the resident was cognitively impaired and required extensive to total assistance for transfers, dressing and hygiene. On 12/13/11 between 4:50 and 5:05 a.m., Resident I were observed fully dressed in her chair at the dining room table with her eyes closed. This resident resided on the Alzheimer's care unit. 8. The record for Resident N was reviewed on 12/15/11 at 1:00 p.m. Current diagnoses included, but were not limited to, Alzheimer's Disease. A 10/05/11 quarterly MDS assessment indicated the resident was cognitively			

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	impaired and required extensive to total assistance for transfers, dressing and hygiene. On 12/13/11 between 4:50 and 5:05 a.m., Resident N was observed awake and fully dressed sitting in her w/c at a dining room table. This resident resided on the Alzheimer's care unit. 9. The record for Resident O was reviewed on 12/15/11 at 1:50 p.m. Current diagnoses included, but were not limited to, Alzheimer's Disease. A 12/5/11 significant change MDS assessment indicated the resident was cognitively impaired and required total assistance for transfers, dressing and hygiene. On 12/13/11 between 4:50 and 5:05 a.m., Resident O was observed fully dressed in her w/c asleep in the dining room. This resident resided on the Alzheimer's care unit. 10. The record for Resident Q was reviewed on 12/14/11 at 9:50 a.m. Current diagnoses included, but were not limited to, dementia.			

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	A 12/9/11 quarterly MDS assessment indicated the resident was cognitively impaired and required extensive assistance for transfers, dressing and hygiene. On 12/13/11 between 4:50 and 5:05 a.m., Resident #Q was observed fully dressed and was brought to the dining room table. At this same time during an interview, CNA #3 indicated he was responsible for having 10 residents on the Birch Lane (Alzheimer's care unit) up before his shift ended at 6:00 a.m. This resident resided on the Alzheimer's care unit. 11. The record for Resident D was reviewed on 12/14/11 at 2:30 p.m. Current diagnoses included, but were not limited to, dementia. A 10/11/11 quarterly MDS assessment indicated the resident was cognitively impaired and required extensive assistance for transfers, dressing and hygiene. On 12/13/11 between 4:50 and 5:05 a.m., Resident D was observed fully dressed and was in his bed with his eyes closed. At this same time during an interview, LPN # 2 indicated the CNA's had to dress the resident. This resident resided on the			

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	Alzheimer's care unit. 12. The record for Resident J was reviewed on 12/15/11 at 11 a.m. Current diagnoses included, but were not limited to, dementia. A 09/26/11 quarterly MDS assessment indicated the resident was cognitively impaired and required extensive assistance for transfers, dressing and hygiene. On 12/13/11 between 4:50 and 5:05 a.m., Resident J was observed dressed in her wheelchair with her eyes closed sitting in the hallway. This resident resided on the Alzheimer's care unit. 13. The record for Resident K was reviewed on 12/15/11 at 11 a.m. Current diagnoses included, but were not limited to, Alzheimer's Disease. A 10/17/11 quarterly MDS assessment indicated the resident was cognitively impaired and required limited to extensive assistance for transfers, dressing and hygiene. On 12/13/11 between 4:50 and 5:05 a.m., Resident K was observed fully dressed			

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	with his head down sitting on the couch in the hallway. This resident resided on the Alzheimer's care unit. 14. The record for Resident L was reviewed on 12/15/11 at 11 a.m. Current diagnoses included, but were not limited to, Alzheimer's Disease. A 10/17/11 quarterly MDS assessment indicated the resident was cognitively impaired and required limited to extensive assistance for transfers, dressing and hygiene. On 12/13/11 between 4:50 and 5:05 a.m., Resident L was observed fully dressed in her wheelchair (w/c) with audible snoring heard. This resident resided on the Alzheimer's care unit. 15. The record for Resident P was reviewed on 12/15/11 at 1:15 p.m. Current diagnoses included, but were not limited to, dementia. A 12/7/11 quarterly MDS assessment indicated the resident was cognitively impaired and required extensive assistance for transfers, dressing and hygiene.			

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	On 12/13/11 between 4:50 and 5:05 a.m., Resident P was observed awake and fully dressed with a cloth protector on sitting in his chair in the dining room. This resident resided on the Alzheimer's care unit. This deficiency relates to the investigation of complaint #IN00101011. 3.1-3(t)			
F0252 SS=C	The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to ensure the facility was clean and in good repair related to torn and peeling wallpaper, broken window sills, accumulation of gray brown dirt around baseboards, missing floor tiles, and light brown spots on ceiling tiles.	F0252	**F252 Safe/Clean/Comfortable/Homelike Environment** It is the practice of this provider to ensure residents are provided with a safe, clean, comfortable and homelike environment, allowing the resident to use his or	01/11/2012

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	This deficit practice had the potential to affect 160 of 160 residents who reside in the building: Findings include: During the environmental tour on 12/15/11 at 9:50 a.m., with the Maintenance Director and the Environmental Service Director the following was observed. The Beauty shop had peeling wallpaper around the light socket on the inside wall. A desk in the hallway going to the therapy gym was missing trim around the top of the desk area. The hallway on Maple Lane had an accumulation of gray brown dirt around the base boards. The visitor elevator had 3 nicks in the 12 by 12 tiles. One nick in the middle of the floor was approximately 3 inches (in) by 2 in. with metal showing through the nick. The nick closet to the elevator door was approximately 2 in by 2 in. The third nick was at the back of the elevator and was approximately .5 inches in length. In room 117, the bathroom entrance had a build up of gray brown dirt around the base boards. The oxygen concentrator		her personal belongings to the extent possible. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Wallpaper has been repaired and /or replaced in Beauty Shop, Room #247,#246, · Desk has been repaired on Hall way to Therapy. · Grey/Brown build up has been cleaned/repaired on baseboard and/or flooring for Maple Lane, Room #117, #240,#222,#233, A hall, Concentrator in Room #117 cleaned, and visitors elevator · Window seal repaired in 2 nd floor lounge and Room #240 · Lamp Shade replaced on lamp in 2 nd floor lounge. · Ceiling tile and wall in Room #220 has been repaired/replaced. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents who reside in the facility have the potential to be affected by the alleged deficient practice. · Staff including Maintenance and Housekeeping Supervisors have been re-educated on 12-27-201 with	

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	had a yellowish half dollar size dry substance on the top. The floor under the tube feeding pump had a yellowish dry substance spattered on the floor. The floor was sticky when walked on. In the second floor resident's lounge, a lamp shade was noted to be held together by paper tape. Also in the lounge was a broken window sill. The Maintenance Director indicated it was a knot hole in the wood. The Hallway on the A wing had a build up of gray brown dirt around the entire baseboards. Also observed on A wing was: Room 240 the baseboard was off by the bathroom, the window sill was loose and broken. Room 247 had peeling wallpaper on the outside wall. Room 246 had wallpaper peeling away in numerous places. On Willow lane the following was observed: In room 220 there were light brown spots noted on the ceiling and wall by the window. In room 222 there was numerous nicks on the floor in varying sizes.		post test administered to evaluate the retention of education by SDC on observing rooms, hallways and equipment needing repair , cleaning, or replaced and to complete necessary maintenance slips for repair/replacement when needed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Preventive Maintenance schedule will be followed to identify areas of repair and/or replacement by Maintenance and Housekeeping Departments. · Customer Care Representative will monitor on daily rounds and report accordingly. · Staff re-educated 12-27-2011 on completing maintenance slips when areas or items are in need of repair or replacement. with post test administered to evaluate the retention of education by SDC **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A “Facility Environmental Review” CQI audit tool will be completed weekly x 4. Monthly x 2, and then quarterly thereafter by Housekeeping Supervisor. The	

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	In room 233 the floor board was pulling away in numerous places. 3.1-19(f)(5)		CQI committee reviews the audits and action plans are developed to ensure safe/clean environment if threshold of 90% not met. **Compliance date: January 11, 2012**	
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observations, interview, and record review, the facility failed to ensure incontinent care was performed in a manner to prevent urinary tract infections (UTI'S) for 3 of 3 supplemental residents observed during incontinent care in a supplemental sample of 13. (Resident #'s 2, 3, and 6) Findings include: 1. On 12/13/11 from 5:05 p.m. to 5:20 a.m., the following was observed: a.) CNA #3 was observed to wheel a cart containing linen with a basin of water on the top of the cart and stopped by Resident #6's room. With gloved hands CNA #3 was observed to wet a washcloth	F0315	**F315 No Catheter, Prevent UTI, Restore Bladder** It is the practice of this provider to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · Residents #2,#3,#6 have been reassessed and have no signs or symptoms of UTI and receive appropriate incontinent care. · C.N.A. #3 has been re-educated on proper	01/11/2012

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	by using the basin of water on the top of the cart and entered Resident #6's room. Next, he was observed to remove a folded blanket from between the resident's legs. At this same time during an interview, he indicated the removed bath blanket was wet with urine, and he used the bath blanket to keep the resident's bed covers dry. With this same washcloth, CNA #3 was observed to wipe from the front of the peri-area to the rectal area one time. He then replaced a clean bath blanket between the resident's legs and repositioned her to complete her care. Resident #6's record was reviewed on 12/15/11 at 1:05 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, and diabetes mellitus. The quarterly minimum data set assessment, dated 10/14/11, indicated the resident was severely impaired with memory problems. She was frequently incontinent of urine and required extensive assistance of 1 to 2 persons for her toileting and hygiene needs. The laboratory studies indicated a urine culture was obtained on 8/10/11 and indicated the growth of Eschorichia coli (bacteria). The faxed physician order, dated 8/12/11, was Cipro (antibiotic) 500 milligrams by mouth 2 times a day for 10 days.		personal care procedure on 12-27-2011 by DNS/Designee with post test administered to evaluate the retention of education, on all shifts. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents residing in this facility who have incontinence have the potential to be affected by the alleged deficient practice. · Licensed Nurses and C.N.A's have been re-educated on appropriate personal care on 12-27-2011 by DNS/Designee with post test administered to evaluate the retention of education, on all shifts. · Non-compliance with facility policy and procedure may result in employee re-education, and/or disciplinary action up to and including termination. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Licensed Nurses and C.N.A's have been re-educated on appropriate personal care · C.N.A.'s will be checked off on a Peri-Care audit sheet by DNS/Designee by 1-11-2012, on all shifts. · The Unit Managers and charge nurses will monitor during rounds of unit for proper peri-care, on all shifts. · The Director of Nursing Services and /or Designee is responsible to	

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	b.) Next, after wetting another clean washcloth from his cart in the same wash basin, CNA #3 entered Resident #2's room. After rolling her over, he removed her diaper. At this same time during an interview, CNA #3 indicated Resident #2 had been incontinent of urine also as all of the residents on this hall were heavy wetters. CNA #3 was then observed to wipe the resident from front to back with the same area of the washcloth 3 times before he put a new diaper on her and repositioned her in the bed to complete her care. Resident #2's record was reviewed on 12/15/11 at 1:20 p.m. The resident's diagnoses included, but were not limited to, dementia with psychosis. The quarterly minimum data set assessment, dated 11/14/11, indicated the resident was severely impaired with memory problems. The resident was always incontinent of bowel and bladder and required total assistance of 1 to 2 persons for her toileting and hygiene needs. The laboratory studies indicated a urine culture was obtained on 6/30/11 and indicated the growth of Citrobacter freundii (citfre). The faxed physician order, dated 7/01/11, was Tobramycin (antibiotic) 80 milligrams intramuscular daily for 5 days.		monitor for compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A "Personal Care" CQI audit tool will be utilized weekly x4, monthly x 2 and quarterly thereafter, to monitor compliance with proper personal care, on all shifts. The CQI committee will review the data. If compliance of 90% threshold is not met, an action plan will be developed. · Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action up to and including termination. **Compliance date: January 11, 2012**	

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	c.) Then, CNA #3 with gloved hands wet another clean washcloth in the same wash basin. After removing Resident #3's diaper, he proceeded to wipe the resident's peri-area in 1 single motion from front to back and covered the resident up. At this same time during an interview, CNA #3 indicated Resident #3 had also been incontinent of urine. At this same time during an interview, CNA #3 indicated he did mix soap in with the water basin for his peri-care and used the cart to help complete his assignment. Resident #3's record was reviewed on 12/15/11 at 1:25 p.m. The resident's diagnoses included, but were not limited to, history of recurrent UTI's and history of renal stones. The annual minimum data set assessment, dated 11/10/11, indicated the resident was severely impaired with memory problems. She was frequently incontinent of urine and bowel and required total assistance of 1 to 2 persons for her toileting and hygiene needs. The resident's care plan, originally dated 12/09/10 and updated 11/22/11, indicated the problem was risk for urinary tract infection related to a history of UTI's, urinary incontinence. The approaches included, but were not limited to, provide peri care after each episode of			

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	incontinence; use peri wash and skin barrier cream each time. 2. The "Perineal Care" policy was provided by the Staff Development Coordinator on 12/15/11 at 1:20 p.m. This current policy indicated the following: "Skill ...Fill wash basin with warm water and have resident check water temperature Put on gloves Assist resident to spread legs and lift knees if possible ...Wipe from front to back and from center of perineum to thighs. Change washcloth as necessary. For Females: Separate labia. Wash urethral first; wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of washcloth for each stroke. ...Change water in basis. With a clean washcloth, rinse area, thoroughly in the same direction as when washing Gently pat area dry in same direction as when washing ...Wet and soap washcloth Clean anal area from front to back, rinse and pat dry thoroughly...." 3.1-41(a)(2)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observations, interviews, and record review, the facility failed to ensure effective infection control practices related to linen and handwashing, which included 1 of 2 linen closets observed	F0441	**F441 Infection Control, Prevent Spread, Linens** It is the practice of this facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable	01/11/2012

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	(Maple Lane), 2 of 5 CNA's observed (CNA #1 and #3) during personal care and linen handling for 5 of 7 residents observed (Resident #41, 45, 2, 3, and 6), and 2 of 6 nursing staff observed (LPN #4 and #5) during medication pass for 5 of 10 residents observed (Resident #'s E, 21, 22, J, 92, and 91). This had the potential to affect 35 of 160 residents residing in the facility. Findings include: 1. On 12/13/11 from 4:35 a.m. to 4:47 a.m. during initial tour, personal clothing was observed on Resident #41's floor next to the bed. As CNA #1 indicated she had completed care and proceeded to exit the room, she was observed to pick up the resident's personal clothing off of the floor. Also, during this same initial tour, linen was observed on the floor in Resident #45's bathroom. 2. On 12/13/11 at 5:40 a.m., the clean linen closet door was opened by an unidentified CNA. Two personal coats were observed hanging on the inside of this door as linen was obtained and the door was again closed with the personal coats remaining on the inside of the closet door. On 12/16/11 at 9:10 a.m. during an		environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident #2,3,6,21,22,41,45,91,92,E and J receives personal care with proper infection control procedures for hand washing, glove use, handling of linen and equipment and in accordance with professional standards of care. · LPN's #4 and #5 and C.N.A.'s #1 and #3 have been re-educated to the hand washing, use of gloves, handling of linen, and storage of personal belongings policy and procedures with post test administered to evaluate retention of education by SDN/DNS/Designee on 12-27-2011. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents who reside in the facility have the potential to be affected by the alleged deficient practice. · Staff has been re-educated on Infection Control Practices for proper hand washing, glove use, handling of linen and storage of personal belongings with post test administered to evaluate retention of education, on all shifts, on 12-27-2011 by	

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	interview, the Housekeeping Supervisor indicated personal coats should not be hung on the inside door of the clean linen closets. 3. On 12/13/11 from 5:05 p.m. to 5:20 a.m., the following was observed: CNA #3 was observed to utilize an uncovered cart containing linen and a basin of water on the top of the cart. With gloved hands CNA #3 was observed to wet a washcloth by using the basin of water on the top of the cart. Next, he was observed to enter Resident #6's room and completed personal care. After removing his gloves, CNA #3 used handgel and donned another pair of gloves. After wetting another clean washcloth from his cart in the same wash basin, CNA #3 entered Resident #2's room and completed her personal care. After removing his gloves, he was observed to handwash. Then, he again donned a pair of gloves, wet another clean washcloth in the same water basin, and completed personal care on Resident #3. At this same time during an interview, CNA #3 indicated he would use the cart to complete his assignment. He also indicated he would mix the soapy water basin he used when he started his rounds around 4:00 a.m. 4. The "Clean Linen" policy was		SDC/DNS/Designee. · DNS is responsible to ensure Infection Control practices are followed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Staff has been re-educated on Infection Control Practices for proper hand washing, glove use, handling of linen and storage of personal belongings with post test administered to evaluate retention of education, on all shifts, on 12-27-2011 by SDC/DNS/Designee · The Unit Managers and charge nurses will monitor resident rooms and common areas for proper infection control practices on all shifts. · Skills check off's for Nurses and C.N.A's will be completed for hand washing, glove use, on all shifts, by DNS/Designee by 1-11-2012. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Non-compliance with facility policy and procedure may result in employee re-education, and/or disciplinary action up to and including termination. · An "Infection Control Review" CQI tool will be utilized weekly x 4, monthly x2 and then quarterly thereafter to monitor compliance with hand washing, glove use,	

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	provided by the Staff Development Coordinator on 12/15/11 at 1:20 p.m. This current policy indicated the following: "* Protect linen from soiling and contamination. ...* Carts/racks should be covered....." 5. On 12/13/11 from 8:09 a.m. to 8:35 a.m. during medication pass, the following was observed: LPN #4 with ungloved hands was observed to prepare and administer Resident #E's insulin subcutaneously in the left mid-abdomen area. She then returned to the medication cart and documented her medication administration before handgel was observed used. Next, LPN #4 prepared and administered Resident #21's oral medications and took her blood pressure and pulse. No handwashing/handgel use was observed. She then proceeded to prepare and administer Resident #22's oral medications. During this medication administration, the used medication cup fell on the floor. Resident #22 requested the medication cup to keep. At this same time during an interview, LPN #4 indicated she did like to keep the medicine cups as she was observed to pick the dropped medication cup up off of		linen handling and storage of personal belongings. The CQI committee will review the data. If compliance of threshold of 90% is not met, an action plan will be developed. **Compliance date: January 11, 2012 F223 Free From Abuse/Involuntary Seclusion** It is the practice of this facility to keep residents right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident #153 continues to reside at the facility and is free from any abuse. Resident #201 no longer resides at the facility. · C.N.A. #7was terminated on 11-14-11 and C.N.A.#8 was terminated on 9-23-11 · Both incidents were reportable events and were reported to the Indiana State Department of Health on 12-13-11 and 9-22-11 respectively. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All residents residing in the facility have the potential to be affected by the alleged deficient practice. · Staff was re-educated on the Abuse Policy at the time of events and on 12-27-2011with	

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	the floor and gave it to the resident. Next, Resident #22 requested a glass of water, which was obtained and given to the resident. No handwashing/handgel use was observed. Then, Resident #J requested a pain medication for her headache. In preparation, LPN #4 was observed to lick her finger to open the plastic sleeve to crush the oral pain medication. LPN #4 was observed to crush the oral pain pill and administer it to the resident after mixing it with applesauce. On 12/14/11 at 2:10 p.m. during an interview, LPN #4 indicated during medication pass one should initially wash their hands and then, can used handgel for 2 residents before one would handwash again. 6. On 12/13/11 from 11:58 a.m. to 12:05 p.m. during medication pass, LPN #5 was observed to prepare and administer Resident #92's insulin subcutaneously in the right mid-abdomen. LPN #5 was observed to handwash, turn the water off with her wet hand, and then, dried her hands. 7. On 12/13/11 from 1:20 p.m. to 1:48 p.m. during medication pass, LPN #5 was observed to prepare and administer Resident #91's gastrostomy tube		post test administered to evaluate retention of education by SDC/DNS/Designee **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Facility will continue not to tolerate any abuse to a resident · It will be the responsibility of all facility staff to monitor/observe for staff mistreatment of residents. Criminal background checks and employment screening will continue to be done prior to employment. · Staff abuse in-services will be completed upon hire and quarterly or more frequent as required with post test administered to evaluate retention of education. · Any suspected abuse allegations will be reported to the Executive Director or Director Nursing Services immediately and the employee will be suspended until investigation completed · For any allegations of abuse the resident will be assessed immediately for negative outcomes and family and physician will be notified with investigation started immediately. · All reportable events of such allegations will be reported to the ISDH. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The CQI tool “Staff Treatment of Resident” will be	

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	medications. In preparation, LPN #5 was observed to place her finger inside the plastic sleeve to open it and place the oral medication inside the sleeve 2 different times before crushing the oral medications for G-tube administration. On 12/13/11 at 12:10 p.m. during an interview, LPN #5 indicated one should handwash for 20 seconds, dry one's hands, and then, turn the water off with the used towels. 8. The following policies were provided by the Staff Development Coordinator on 12/15/11 at 1:20 p.m. These current policies indicated the following: "Medication Pass Procedure Skill: ...Hands washed following administration (gel x [times] 5 then water) unless resident contact then wash hands after....." "Hand Washing Skills Check Skill: ...Rinse thoroughly, running water down from wrist to fingertips Pat dry with paper towel Turn off faucet with paper towel and discard towel immediately...."		completed weekly x4, then monthly x2, and then quarterly thereafter. · The managers and charge nurses in the facility will be responsible to monitor for compliance. · The CQI committee reviews the audits monthly and action plans developed as needed to ensure compliance if threshold of 90% not met. · Non-compliance with facility policy and procedure may result in disciplinary action up to and including termination. **Compliance date: January 11, 2012**	

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